DMHC use only

Call Ref. # _____

CONSUMER COMPLAINT FORM

Complete this form only if you have completed the formal grievance/appeal process with your health plan and are not satisfied with the resolution or if your health plan did not resolve your grievance within 30 days. ***However, if your complaint involves an imminent and serious threat to the health of the patient, immediately contact the HMO Help Line toll free at (888) HMO-2219 or TDD (877) 688-9891.*** **Please type or print clearly.**

1. **Complainant's Name:** _____
   Street Address: _____
   City: _____ **State:** _____ **Zip:** _____
   Telephone: (Daytime): _____ (Evening): _____
   Cell Phone: _____ **E-mail Address:** _____

2. **Patient's Name and Address: (Only if different from Complainant):**
   _____
   _____
   _____

3. **Health Plan Name:** _____
   Medical Group Name: _____
   Medical Group #: _____
   Patient's ID # (or Membership #): _____
   Patient's Date of Birth: _____

4. **Are you a Medi-Cal Beneficiary?** **Yes** ____ **No** ____
   Are you a Medicare Beneficiary? **Yes** ____ **No** ____

5. **Have you previously filed a formal grievance/appeal with your health plan regarding this complaint?**

   If <u>YES</u>, date(s) of contact: _____
   Person(s) contacted: _____
   Telephone: _____

   If <u>NO</u>, you must first complete the formal grievance/appeal process with your health plan (see Consumer Complaint Process section "How Does the Complaint Process Work?").

6. Please fully explain the essential facts of this complaint. What health plan service did you not receive? What was wrong with the service received? What billing issues do you have? Explain who, what, where, when, and how. Please attach photocopies of any correspondence you received from the plan, and any other documents that you believe support your complaint. Attach additional paper, if more space is needed. (Dates of Service & Provider Information are required.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

7. If your complaint involves care or treatment provided by an individual provider (i.e., a doctor, nurse, or dentist), do you authorize the DMHC to forward this complaint to the agency that has jurisdiction?
Yes ____ No ____

8. What is your diagnosis related to this complaint? _____
_____

9. What treatment(s) have you received related to this complaint?
_____
_____

10. Have you reported this to any other government agency?
Yes ____ No ____
Agency and file number *(if known)*:
Agency _____ File Number _____

11. Is there a lawsuit pending? Yes ____ No ____
If yes, attach a photocopy of the court documents and provide:
Name of the County where filed: _____
Case Number: _____ Date Filed: _____
Name of Representing Attorney: _____
Telephone: _____

I understand that providing the information is not mandatory, but failure to do so may delay or even prevent further consideration of a resolution on my complaint. I understand that a copy of this complaint may be sent to my health plan.

_____ _____

Signature of Complainant **Date**

_____ _____

Signature of Patient, if adult **Date**

If you have any questions or need assistance completing this form, call our HMO Help Line toll free at (888) HMO-2219 or TDD (877) 688-9891.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ ***on behalf of*** _____
Person Authorizing Release **Patient**

hereby authorize _____
Health Plan

to release to the Department of Managed Health Care (Department) the medical record(s) in the custody and/or control of the Health Plan, including applicable mental health records, concerning care provided to the patient relating to the Complaint filed with the Department.

This authorization for release of information may be revoked or withdrawn at any time and revocation or withdrawal will apply to all information not previously released to the Department. This authorization will expire one year following the date indicated below and the expiration will apply to all information not previously released to the Department. Your medical records will only be obtained if it is determined to be necessary in order to complete a review of your Complaint. This information will be kept confidential.

THIS MEDICAL AUTHORIZATION IS NOT MANDATORY. HOWEVER, FAILURE TO SIGN THIS RELEASE MAY PREVENT FURTHER ASSISTANCE ON YOUR COMPLAINT.

_____ _____
Signature of Complainant **Date**

_____ _____
Signature of Patient, if adult **Date**

If completing on behalf of another adult, a signature is required from that individual. If you have Power of Attorney on behalf of another individual, please provide us with a copy of the legal document.

Please sign the Complaint Form and the Authorization for Release of Medical Records. Attach photocopies of all relevant documents and records, as originals cannot be returned.

Fax these documents to: **(916) 229-0465** **or**

Mail to: **Department of Managed Health Care**
California HMO Help Center
980 Ninth Street, Suite 500
Sacramento, CA 9581

Gray Davis, Governor
State of California
Business, Transportation and Housing Agency

980 Ninth Street, Suite 500
Sacramento, CA 95814
888-HMO-2219 voice
916-229-0465 fax
hmohelp@dmhc.ca.gov e-mail

NOTICE REQUIRED BY
THE INFORMATION PRACTICES ACT OF 1977
(California Civil Code Section 1798.17)

a) The HMO Help Center of the Department of Managed Health Care of the State of California requests the information solicited by the forms attached to this Notice.

b) The Chief Administrative Officer, 980 9th Street, Sacramento, CA 95814-2725, telephone number (916) 327-7659, is responsible for the system of records and shall, upon request, inform individuals regarding the location of the Department of Managed Health Care's records and the categories of persons who use the information in the Department of Managed Health Care's records.

c) The Department of Managed Health Care's records are maintained pursuant to one or more of the following statutes: Health and Safety Code Sections 1344, 1351, 1351.1, 1352, 1353, 1368(b), 1368.02 and 1384.

d) The submission of all items of information is voluntary.

e) Failure to provide all or any part of the information requested by the attached form may preclude the HMO Help Center of the Department of Managed Health Care from reviewing your complaint.

f) The principal purposes within the Department of Managed Health Care for which the information is to be used is as part of the process to determine: (1) whether a license, qualification, registration or other authority should be granted, denied, revoked or limited in any way; (2) whether business entities or individuals licensed or regulated by the Department of Managed Health Care are conducting themselves in accordance with the applicable laws; and/or (3) whether laws administered by the Department of Managed Health Care are being or have been violated and whether administrative action, civil action, or referral to appropriate federal, state or local law enforcement or regulatory agencies is appropriate.

g) Any known or foreseeable disclosures of the information pursuant to subdivision (e) or (f) of Civil Code Section 1798.24 may include transfers to other federal, state, or local law enforcement or regulatory agencies.

h) Subject to certain exceptions or exemptions, the Information Practices Act grants an individual a right of access to personal information concerning the requesting individual, which is maintained by the Department of Managed Health Care. However, Government Code Section 6254 provides that records of complaints to or investigations conducted by the Department of Managed Health Care are exempt from disclosure except as required by law.

Additionally, Evidence Code Section 1040 provides a privilege against disclosure of official information where a court determines that the necessity for confidentiality outweighs the public interest in disclosure.